Office of Health Care Quality Regulation Review Public Comments:

COMAR 10.07.02 (Sections .13 - .21)

The Office of Health Care Quality (OHCQ) within the Maryland Department of Health and Mental Hygiene (DHMH) extends its gratitude for all of the comments, suggestions, and recommendations suggested by our valued stakeholders. Due to your efforts we have been able to revise and update COMAR 10.07.02 Comprehensive Care Facilities and Extended Care Facilities. A public comment period was held September 26, 2014 through November 14, 2014 to collect input on the draft regulation. This document represents the public comments received as of December 31, 2014.

During the public comment period, the draft regulation was posted on the Office of Health Care Quality's website and distributed to the public through emails and stakeholder meetings. Individuals and groups had the opportunity to submit comments through an electronic public comment form, email, or in person. Three public stakeholder meetings were held on site at the OHCQ. The meetings were advertised on the OHCQ website, through the email distribution list, and word of mouth.

Comments and Responses – This document contains responses to all substantive comments received on the Draft COMAR 10.07.02, organized by regulation in the order of regulations presented in the Draft COMAR 10.07.02 (i.e., beginning with .01. Definitions). Similar comments were combined and are addressed below.

Each comment has been coded by the letter C for comment, regulation number and comment's sequential order. For example, the first comment for .01 Definitions would be denoted as "C.01-1". The second comment is "C.01-2".
If you have any questions please contact Amanda Thomas at Amanda.thomas@maryland.gov.
Thank you once again for your continued participation and partnership.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

Office of Health Care Quality Regulation Review Public Comments:

COMAR 10.07.02 (Sections .13 - .21)

.13 Dietetic Services

	Comment	Response
C.13 - 1	Multiple comments were received for COMAR 10.07.02.13 (C)Dietetic Services. Most commenter's opposed OHCQ's proposed regulation, which included a chart that specified a required number of weekly registered dietitian clinical hours based on the number of licensed beds.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.13 - 2	13. B1(1) Dietetic Services (page 23 of 77): suggest inclusion of time period of up to one year / 12 months for completion of certification program, to allow new hire to achieve "certified dietary manager" accreditation.	OHCQ promotes the hiring of qualified certified dietary managers.
C.13 - 3	.13B—Supervision The Maryland Department of Aging (MDoA) supports the requirement of a certified dietary manager.	OHCQ appreciates your comment.
C.13 - 4	.13G—Frequency and Quality of Meals 42 CFR 483.35(d)(4) requires that Medicaid and Medicare participating facilities provide substitutes of similar nutritive value to residents who refuse food served. The proposed regulations do not make that clear so the following sentence should be added to Regulation .13G, "Residents who refuse food served shall be provided substitutes of similar nutritive value."	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.13 - 5	.13H—Advance Planning and Posting of Menus MDoA commends OHCQ for adding the language "Residents shall be given the opportunity to participate in planning menus." Meals are central to quality of life and quality of care for residents. Providing meal selection choices and accommodating individual preferences of residents who come from	OHCQ appreciates your comment.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

	Comment	Response
	diverse communities and backgrounds results in improved health and resident satisfaction.	
C.13 - 6	.13L—Resident Directed Meal Pattern The use of the word “approved” in this part is inappropriate. The physician and dietitian may not “approve” of a resident’s dietary choices. But this provision is to encourage resident direction and choice so it should read “If a resident directed meal pattern is provided: (1) counseling regarding the risks and benefits of resident-selected diet should be provided and documented within the medical record, and (2) the plan shall be acknowledged by both the resident’s physician and dietitian.”	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.13 - 7	Please use the term, "licensed registered dietitian"	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.13 - 8	Page 24 - .13 Dietetic Services; C. Consultation; section (1) We agree with the removal of "or other qualified person" from this section.	OHCQ appreciates your comment.
C.13 - 9	Page 25 - .13 Dietetic Services; F. Therapeutic Diets; section (1). We agree with the removal of "or other qualified person" from this section.	OHCQ appreciates your comment.
C.13 - 10	Page 24 - .13 Dietetics; C. Consultation . The requirement as it is currently stated should remain.	OHCQ appreciates your comment.
C.13 - 11	.24, .13Dietetic Services, C. Consultation 1. We agree with a CDM being required for Dietary Managers. CDM is a test that can be taken for many culinary arts and DTR's without course work and guarantees Managers will be able to safely manage a kitchen and a food service.	OHCQ appreciates your comment.

	Comment	Response
C.13 - 12	Page 24, .13, D. Staffing. I support this section as it is written. While I agree with changes in cultures, it is important if Nursing, housekeeping, laundry, or other personnel are adequately trained in food safety and the areas they are expected to replace food service personnel in addition "to the written approval of the Department."	OHCQ appreciates your comment.
C.13 - 13	Please spell dietitian with 2 t's not dietician. Thank you.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.13 - 14	13 (D)(3) Nursing, housekeeping, laundry, or other personnel may not be utilized as dietetic staff. Exceptions may be made only upon the written approval of the Department. The kitchen may not be used for any purpose other than the preparation of food. Voices Input: Please reconcile this regulation to accommodate the growing use of universal workers and the kitchen set-ups of Green House and other culture change facilities. As written, this regulation is obsolete.	Facilities that desire to deviate from the standard dietetics staff pattern and use of kitchen space, shall request a waiver. OHCQ will review the waiver to ensure the requested changes are appropriate and do not negatively impact the health and safety of residents.
C.13 - 15	.13 G. Frequency and Quality of Meals. If the four-or five-meal-a-day plan is used, the meal pattern to provide this plan shall be approved by the Department. Why was this eliminated? This will need to be modified to accommodate the free choice of eating times and food content for people living in any Culture Change facilities. We feel it should be altered to accommodate individual food choice and eating times for all people living in Maryland nursing homes.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.13 - 16	The changes made to C.(1) are confusing and should be reconciled with the	OHCQ appreciates your comment.

	Comment	Response
	definition of certified food manager.	

.14 Specialized Rehabilitative Services

	Comment	Response
C.14 - 1	.14-2C (Page 27 of 77): Thank you for revising the language that would allow a facility to hire or contract with a Board-Certified Pulmonologist.	OHCQ appreciates your comment.
C.14 - 2	.14-2D.1 (Page 27 of 77): The requirement for either the nurse manager of a Respiratory Care Unit or the Director of Nursing to have ventilator management qualifications should only apply to facilities that have ventilator care units and not broadly to all facilities with respiratory units.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.14 - 3	.14-3B (page 28 of 77): The proposed regulation refers to “locked units.” The preferred language here should be “secured units” as this may present a dignity issue.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.14 - 4	Regulation .14-3 Special Care Units—Dementia Care MDoA commends OHCQ for creating a committee that will be addressing Dementia Care Unit standards including staff training and activities to be included in the proposed regulations. We look forward to participating on this committee because it is important that residents on these units receive the specialized care they need and that their families and legal representatives are informed about what differentiates a special unit from other parts of the long term care facility.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.14 - 5	Restorative nursing care supports maintenance of body function. Nursing time must include staff instruction of	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.

	Comment	Response
	goals for each resident & supervision.	
C.14 - 6	More needs to be done to strengthen both the respiratory unit section and the dementia unit section.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.14 - 7	.14 (C.) Policies and Procedures need to be submitted to the Resident Council and to a Family Council, if there is one, and any comments seriously considered before implementation.	The provision of the nursing facilities policies and procedure are addressed in COMAR 10.07.09 Residents' Bill of Rights: Comprehensive Care Facilities and Extended Care Facilities. The regulations don't limit residents, interested family members, or representative's option to request further information from facilities.
C.14 - 8	.14 (G.) Therapies may not be discontinued due to lack of progress if they are necessary to maintain current status.	The interdisciplinary team including physician and rehabilitation team are required to review the resident's progress and reevaluate the resident's needs.
C.14 - 9	.14 (J.) Job Descriptions. Should be available to the general public in the same way the survey reports are made available.	The provision of the descriptions for rehabilitative services personnel shall be readily available in the facility. The regulations don't limit residents, interested family members, or representative's option to request further information from facilities.
C.14 - 10	10.07.02.14-1(F.) Staffing. It has not proved successful in nursing homes to leave the decision as to whether any unit is "sufficiently staffed with qualified personnel to provide appropriate treatment and carry out the special care needs of the people living in that unit". Suggest that a personnel schedule indicating number and qualifications of personnel by shift be submitted to OHCQ for approval.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.14 - 11	10.07.02.14-2(B)(2)(a) Names, Qualifications, duties, and responsibilities of staff, including the	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

	Comment	Response
	staff who are permitted to perform the following procedures: (i) Cardiopulmonary resuscitation; This needs to include the ability to perform cardiopulmonary resuscitation on people with tracheostomies!	
C.14 - 12	(D)[(1)] (2) Respiratory care services are provided by a sufficient number of qualified personnel; Suggest that a personnel schedule indicating number and qualifications of personnel by shift be submitted to OHCQ for approval.	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.14 - 13	.14 – 2 (E)(2) Ventilator Alarms. The facility shall ensure that each ventilator is equipped with an alarm on both the pressure valve and the volume valve for safety. The alarms shall "be fully functional at all times"	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.14 - 14	Recommendation: 1. While there is a back-up for power in the form of a generator, no where in the regulations is there a requirement for a back-up generator to be present in the room of each ventilator-dependent person. Research suggests that 5 to 6 minutes is the maximum time a person can survive without brain damage once a ventilator ceases to function. This does not leave much time for replacement. It is critical that a replacement ventilator be readily available and able to be put into action within those 5 minutes. No one will have time to look for one once an emergency commences. It takes considerable to just make this switch.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.14 - 15	10.07.02.14-2(D) Staffing. The facility shall ensure that: (1) The nurse manager or the Director of Nursing must possess a background in ventilator care or	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.

	Comment	Response
	ventilator management qualifications. (Add the following language) (D)(2) -- Respiratory Care Services are provided by a sufficient number of qualified personnel as follows: 1-10 patients = 1 RN. 11-14 patients = 1 RN + 1 LPN. 15-20 patients = 2 RNs. ADD (3): Respiratory services shall be provided by a licensed respiratory therapist on-site 24 hours a day. Respiratory therapists will provide care in an appropriate ratio according to patient acuity not to exceed 1 therapist to 10 ventilator-dependent residents. These additions were taken directly from the Georgia regulations and approach the best practices standard -- which current Maryland regulations for ventilator units do not.	
C.14 - 16	In section .14E (page 26 of 77), it states, "Unless medically contraindicated, the physician shall discuss ..." I've discussed this with my colleagues in the Ombudsman Program, and we can't think of any circumstance under which the physician should not discuss the planned rehab program with the resident or the family. Delete "Unless medically contraindicated,"?	The Patient's Bill of Rights states, "(patients) are fully informed by a physician of their medical condition unless medically contraindicated". OHCQ has not made this change, as we believe the federal regulation support the regulation as written.
C.14 - 17	Given the change from 48 hours to 36 hours, would also request that language be added to the exclusion of Saturday and Sunday to include State and federal holidays as well, especially when they occur concurrent with the weekend (Friday and Monday).	OHCQ has not made this suggested change, as OHCQ believes that facilities should be open and available to the extent possible on state and federal holidays.
C.14 - 18	Request clarification that the language in D.(1) be amended to state "The nurse manager **for the respiratory care unit** or the Director of Nursing…."	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.14 - 19	.14-2 Special Care Units — Respiratory	OHCQ appreciates your comment.

	Comment	Response
	Care Unit .14-2C (Page 27 of 77): Thank you for revising the language that would allow a facility to hire or contract with a Board-Certified Pulmonologist.	
C.14 - 20	.14-2D.1 (Page 27 of 77): The requirement for either the nurse manager of a Respiratory Care Unit or the Director of Nursing to have ventilator management qualifications should only apply to facilities that have ventilator care units and not broadly to all facilities with respiratory units.	OHCQ convened a stakeholder work group to review and make recommendations for the regulation.
C.14 - 21	.14-3 Special Care Units-Dementia Care The proposed regulation refers to "locked units." The preferred language here should be "secured units" as this may present a dignity issue.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.

.15 Pharmaceutical

	Comment	Response
C.15 - 1	15A.2 (page 28 of 77): Can the written pharmacy policies and procedures be developed by the parent company if the facility's Pharmaceutical Services Committee approves?	OHCQ appreciates your comment; additionally OHCQ's response to your question is yes.
C.15 - 2	.15A.2.e (page 29 of 77): The facility may have specific drug distribution processes that require certain packaging. The facility should be able to decide if the packaging system is acceptable. For example, some facilities have medication carts set up for bingo cards. To have medications in vials, boxes, etc. would present an issue for the staff at the center.	OHCQ appreciates your comment.
C.15 - 3	.15A.3.b (Page 29 of 77): The Pharmaceutical Service Committee is	OHCQ appreciates your comment; additionally OHCQ's response to your

	Comment	Response
	required to meet quarterly. Can these quarterly meetings be a part of the Quality Assurance committee meetings, provided it contain all the items listed.	question is yes.
C.15 - 4	.15B.3.b.iii (Page 30 of 77): All references to “pharmacist” should be to “pharmacy.”	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 5	.15B.3.d (page 31 of 77): The pharmacy shall be responsible for delivering medications to the facility, not the pharmacist as stated.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 6	.15D.1.ix (page 32 of 77): This should be prescription number, not serial number as stated.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 7	.15D.1.v (Page 32 of 77): “Prescribing physician” needs to be changed to “authorized prescriber.”	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 8	Duplication of regulations: • B(2)(e) – Duplicates E(2)(d)(iii) • B(3)(a) – Duplicates B(3)(b)(iv) • B(3)(b)(iii) – Duplicates B(2)(c) • B(3)(b)(v) – Duplicates B(3)(g) Misnumbering of regulations: • D(1)(i)-(xi) – should be D(1)(a)-(k) • E(1)(i)-(v) – should be E(1)(a)-(e) • E(1)(j) – should be E(2), and E(2) should be E(3)	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 9	Please use the term, "licensed registered dietitian"	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 10	Page 29: .15 Pharmaceutical; A Medication Administration; (1) Duties of the Pharmaceutical Services Committee; (a) composition of the committee; (iii) the consultant dietitian Our organization agrees there is a need to include the licensed, registered dietitian in this committee. We recommend the wording be changed from “consultant dietitian” to “licensed, registered dietitian”.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.

	Comment	Response
C.15 – 11	P. 28-29, Section A, 2, ii, Agree with Consultant Licensed, Registered Dietitian being a part of the Pharmacy Committee, being available as the agenda requires	OHCQ appreciates your comment.
C.15 - 12	On 10.07.02.15 generally: OHCQ, and the State of Maryland, over the years, have allowed the pharmacy industry and other providers to circumvent the federal regulations for nursing homes in a number of incidences. This has created conflicting regulations in COMAR. A number of those conflicts is apparent in section 10.07.02.15, Pharmaceutical of COMAR. These pharmaceutical regulations are of vital concern to our members. We continually have complaints regarding provisions in this section of COMAR. 10.07.02.15	OHCQ appreciates your comment.
C.15 - 13	(A)(1) Check spelling of "biologicals"	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 14	ALSO ADD "without abridging the person's federal right to a choice of a pharmacy."	OHCQ has not made this suggested change, as OHCQ believes the regulation is sufficient as written.
C.15 - 15	(A)(2) Add (vi) One representative from the Family Council if there is one. (Reference QAPI)	OHCQ has not made this suggested change, as OHCQ believes the pharmaceutical services committee is sufficiently staffed with a pharmacist, director of nursing, licensed registered dietitian, physician, and administrator.
C.15 - 16	2 regulations seem to be in conflict. Please reconcile. 10.07.02.15 (B)(1) and 10.07.02.15 (A)(2)(e).	OHCQ has not made any changes, as OHCQ believes the two regulations do not conflict. COMAR 10.07.02.15 (A)(2) outlines the roles, responsibilities, and authority of the pharmaceutical services committee. The committee lacks the authority to require a pharmacy to provide drugs by way of a specific drug

	Comment	Response
		distribution system such as unit dose. COMAR 10.07.02.15 (B)(1) outlines the process a facility must follow to implement a unit dose system.
C.15 - 17	10.07.02.15 (B)(1)(a) Medications not specifically limited as to time or number of doses, when ordered, shall be automatically stopped in accordance with the written policy originated by the committee. ADD "with notification of and permission from the person living in the nursing home or that person's legal representative." We've had too many instances where medications have been wrongly discontinued. Reinstating them is not as easy as one might think!	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.
C.15 - 18	10.07.02.15(2) (b) Suggest you move "certified graduates of a State-approved medication aide course" to a position directly after "licensed personnel".	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 19	10.07.02.15(2)(e) Before invoking stop order policies, the patient's attending physician shall be contacted for instructions so that continuity of the patient's therapeutic regimen is not interrupted. Add: after "physician" add "the person or the person's legal representative."	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.
C.15 - 20	10.07.02.15(B)(3)(b)(iii) This section conflicts with 1. federal right to choice of pharmacy, 2. state right to a choice of pharmacy. EXAMPLE: (A)(2)(d) Policies and procedures developed by the pharmaceutical services committee may not prohibit or restrict a resident from receiving medications from the pharmacy of the resident's choice. SEE	COMAR 10.07.02.15 (B)(3)(b)(iii) outlines the process a resident must follow if they desire a particular pharmacist outside of the designated pharmacy of the facility. If the resident's first choice of pharmacy declines to provide services for any reason, they are encouraged to select a different pharmacy. The regulations do not limit the choices of pharmacy to the resident.

	Comment	Response
	ALSO: (10.07.09.08(7)) Residents Rights: Choose a pharmacy to obtain medications as set forth in COMAR 10.07.02.15B(3) and D(3);	
C.15 - 21	Commenter's INPUT: In revising this section, you have renumbered which should have caused you to renumber all referring regulations such as the one quoted above which is no longer accurate since there now is no COMAR 10.07.02.15 (D)(3).--circular reference!	OHCQ appreciates your comment.
C.15 - 22	(B)(3)(b) Please clearly state that this is a consulting pharmacist and that this consulting pharmacist shall serve all people living in the facility regardless of where they obtain their medications.	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.
C.15 - 23	10.07.02.15(d) Unique to Maryland. This is a serious problem. It allows a local drug dealer to deliver medications but not family members. Any resident or resident's representative choosing to exercise the right to choose a pharmacy will need to have a family member delivering the medications. Anyone with Tri-Care or any other prescription insurance plan that requires mail order pharmaceuticals for best price is injured by this regulation. We would like to see it deleted entirely. This also is becoming a civil rights issue.	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.
C.15 - 24	There is no definition of "sponsor" in the regulations.	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.
C.15 - 25	10.07.02.15(e) These two regulations seem to conflict with one another. This is a major issue in programs currently aimed at moving people out of nursing homes and into in	OHCQ appreciates your comment.

	Comment	Response
	home and community-based care. This is not something to be handled lightly in a fast discussion. We have already had meetings with State staff persons trying to facilitate a smooth transition in these cases. Suggest you coordinate with Money Follows the Person staff, the Board of Pharmacy, and the Medicaid devision of DHMH in remedies that will allow people leaving a nursing home to obtain medications from a community pharmacy on an expedited basis.	
C.15 - 26	10.07.02.15(D)(2) Nurses may not package, repackage, bottle, or label in whole or in part any medication, or alter in any way by tampering or defacing any labeled medication. PLEASE ADD "except for the preparation of LOA medications or in the case of a discharge" Otherwise it conflicts with 10.07.02.15(C).	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.
C.15 - 27	10.07.02.15 E. Storage This needs to be altered to accommodate the current best practice of having individual medicine lockers located in each individual resident's room or in the hallway near the door to the room. These are locked storage places. They do a lot to minimize medicine errors, and should not need a "waiver" to install!	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.
C.15 - 28	On page 26, subsection (c), Request that the language be changed to “all members of the committee shall review and have an opportunity to comment on revisions of policies and procedures before the implementation of any changes” rather than all committee members must agree. The proposed language fails to provide any authority for the administrator to	OHCQ agrees with these concerns and has made appropriate modifications in the final regulation.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

	Comment	Response
	implement a policy when there is one person disagreeing. Currently, this language is not contained in the regulation and appears to be very prescriptive into the daily activities in a nursing facility.	

.16 Laboratory and Radiologic Services

No Comments Received.

.17 Dental Services

	Comment	Response
C.17 - 1	A resident should have routine dental hygiene, e.g., have his or her teeth brushed, at least once a day. It is unfortunate that presently this does not happen in our nursing homes. Residents can go for days without out having any dental hygiene. Thus, Regulation .17C should be revised to read: Nursing service personnel shall assist the [patient] resident in carrying out routine dental hygiene at least once a day. Please note two things. First, the new defined term is "nursing service personnel," not "nursing personnel" so we have also made this change. Second, this language is replicated in Regulation .12O(8) so the two provisions should be made identical to avoid any confusion.	OHCQ agrees generally with these concerns and has made appropriate modifications in the final regulation.
C.17 - 2	Nursing staff time mjust allow for support of daily dental hygiene and care of dentures for each resident.	OHCQ appreciates your comment.
C.17 - 3	We echo concern re: appropriate dental services being provided by staff. This is exceptionally important in light of the fact that dental care (aside from emergency dental care) and dentures are very difficult to obtain in nursing	OHCQ appreciates your comment.

	Comment	Response
	homes, so if poor dental hygiene is not maintained and/or dentures are lost, it is very difficult to get back to a place of dental health.	
C.17 - 4	Dental Services. Please provide a clearly written definition of "routine" and "emergency" dental services. This is an on-going struggle for all persons living in our Maryland nursing homes.	OHCQ has not made the suggested change, as the terms are defined in the federal regulations. OHCQ believes the regulation is sufficient as written.
C.17 - 5	10.07.02.18(B) Designated Staff Responsibility. We have a Director of Nursing who is trained for and responsible for the Quality of Care in the facility. We need an equal counterpart who is trained for and responsible for the Quality of Life in the facility. This person must be a certified Social Worker with experience in Quality of Life activities and must head the chain of command that includes the Social worker (if the population requires more than one which nursing homes with more than 40 residents will) the Activities program and any other Quality of Life services. At a minimum every nursing home must have a licensed social worker on staff. No consultants. It's time these folks had a full time or more certified social worker(s). Given the size of the nursing staffs, requiring only a social work consultant responsible for Quality of Life is grossly inadequate to meet the needs of the people living in the facility.	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

Office of Health Care Quality Regulation Review Public Comments:

COMAR 10.07.02 (Sections .13 - .21)

.18 Social Work Services

	Comment	Response
C.18 - 1	B. should read as follows: Social Work Staff Responsibility. An LBSW, LGSW, LCSW or LCSW-C from the facility shall be assigned responsibility for social services. If the social worker is not a licensed certified social worker(LCSW) or a licensed certified social worker-clinical (LCSW-C), the facility shall provide for an LCSW or LCSW-C to provide sufficient hours of supervision and or consultation to insure that the staff's services meet the biopsychosocial needs of the residents.	OHCQ agrees generally with these concerns and has made appropriate modifications in the final regulation.
C.18 - 2	In regards to Section .18 and LTC facilities requiring an LCSW-C is not an appropriate recommendation. It is also not necessary as any other licensed Social Worker that is trained is more than capable and possibly even better than an LCSW-C. An administrator often has a BA, a DON often only has an RN degree! Now the SW has to have the highest credentials. Its prejudiced.	The regulation solely requires a licensed certified social worker (LCSW). The LCSW-C is required if the position will supervise other staff.

. 19 Resident Activities

	Comment	Response
C.19 - 1	(B). Staffing. A staff member qualified by experience or training shall be appointed to be responsible for the activities program. If the designee is not a qualified [patient] resident activities coordinator as defined in [Regulation .01Y,] Regulation .01 (B) (79) of this chapter, the Department may approve the designee based on the person's education, performance, and Long-term care is finally evolving and person-directed care is the word of the	OHCQ agrees generally with these concerns and has made appropriate modifications in the final regulation.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.

	day. In this milieu, activities plays a critical role. It is important that the Activities Director and staff be certified. Moreover, it is necessary that provisions for individual activities be recorded in all care plans. Boredom kills almost as fast as nosocomial infections.	
C.19 - 2	Electronic Records. Thank you!	OHCQ appreciates your comment.

.20 Clinical Records

	Comment	Response
C.20 - 1	Proposed Regulation .20I(4) states, "Facilities shall provide full access to electronic health records to representatives of the Department as set forth in 10.07.02.05 and other legal representatives as set forth in 10.07.09.08." Two concerns with this language. First, not all persons or entities that a resident may authorize the release of records to under 10.07.09.08 will qualify as "legal representatives." Second, in certain circumstances set forth in Human Services Article Section 10-905, an ombudsman is entitled to review a resident's records. Because ombudsmen have had recurring problems with this issue, it should be addressed. Therefore, commenter recommends that Regulation .20I(4) be revised to read: Facilities shall provide full access to electronic health records to representatives of the Department as set forth in 10.07.02.05, to an ombudsman as set forth in Human Services Article Section 10-905, and to others legal representatives as set forth in 10.07.09.08. (We recommend the	OHCQ has not made the suggested change, as OHCQ lacks the regulatory authority to make this change.

	Comment	Response
	deletion of the word “full” because in certain circumstances access under 10.07.09.08 or under Human Services Section 10-905 may be limited in some respects. 10.07.02.05 makes clear that OHCQ is to have full access. The revisions we propose make clear that the access to be given to electronic health records is to be the same as prescribed under the three referenced authorities: 10.07.09.08, HSA Section 10-905, and 10.07.02.05.)	
C.20 - 2	Might want to consider adding "and applicable State laws." I'm not sure what State laws would be applicable, but we in DHMH have records retention policies and records storage policies that we have to adhere to that are required by law.	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written.

. 21 Infection Prevention and Control Program.

	Comment	Response
C.21 - 1	Multiple comments were received for this regulation 10.07.02.21-1.	OHCQ has not made the suggested change, as OHCQ believes the regulation is sufficient as written. This section was written and endorsed by the Infectious Disease Bureau within the Department of Health and Mental Hygiene. OHCQ has chosen to continue with the recommendations of the Bureau.

The table provides an overview of all responses as provided through the online comment platform. The staff of OHCQ did not make any changes or corrections of grammar in the comments.